

**Maryland State Board of Dental Examiners
Spring Grove Hospital Center • Benjamin Rush Building
55 Wade Avenue
Catonsville, Maryland 21228
(410) 402-8509**

**APPLICATION FOR REINSTATEMENT OF EXPIRED 2011
DENTAL RADIATION TECHNOLOGIST CERTIFICATE**

Notice For Mailing List:

The information collected on this application form is collected for the purposes of the Board's functions under Annotated Code of Maryland, Health Occupations, Title 4. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, State Gov't §10-617, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

SECTION I – NAME AND ADDRESS

Law requires certificate holders to notify the Board of a name or address change within 60 days.

Name (Last, First, Middle Initial):	
Street Address:	
City, State, Zip:	

REINSTATEMENT FEES – PAYABLE TO MARYLAND STATE BOARD OF DENTAL EXAMINERS

Dental Radiation Technologist - \$118.00

SECTION II – GENERAL INFORMATION

A. Social Security Number: - -

(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

B. Home Phone Number: - -

C. Work Phone Number: - -

D. Date of Birth - -

E. E-Mail Address:

F. Hispanic or Latino Origin

Are you of Hispanic or Latino Origin? { Yes } { No }

G. Race: (Multiracial individuals may select all applicable racial categories). { American Indian or Alaska Native
{ Asian { Black or African American { Native Hawaiian or other Pacific Islander { White { Other

H. Gender: { Female { Male

I. Have you practiced dental radiation technology, which is the placement or exposure of dental radiographs, on or after April 2, 2011? ☐ Yes ☐ No If yes, provide the date(s) _____

J. Provide the name, address, and telephone number of the dental office or offices at which you were employed on April 2, 2011, including the name of your supervising dentist(s). _____

SECTION II –GENERAL INFORMATION (CONT'D)

K. Licensure in other states:

List other states or jurisdiction in which you hold a dental radiation technologist certification or license. Include certification/license number(s).

State	Certification/License Number

SECTION III - CHARACTER AND FITNESS:

If you answer "YES" to any question(s) in Section III – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.

The following questions pertain to the period starting on March 2, 2009 and ending March 1, 2011.

YES NO SINCE MARCH 1, 2009

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity denied your application for certification, licensure, reinstatement or renewal, or taken any action against your certificate or license, including but not limited to reprimand, suspension, revocation, a fine, or non judicial punishment? If your are under a Board Order in a state other than Maryland and the Order was effective on or after March 2, 2007, you must enclose a certified legible copy of the entire Order with this application. |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board or any federal or state entity? |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Has your application for certification or licensure been withdrawn for any reason? |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system? |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Have you had any denial of application for privileges, failure to renew your privileges or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system. |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations? |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances? |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Are there any criminal charges pending against you in any court of law, excluding minor traffic violations? |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Do you have a physical or mental condition that currently impairs your ability to practice dental radiation technology? |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession? |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Do you illegally use drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Have you surrendered or allowed your certificate or license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity? |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Have you been named as a defendant in a filing or settlement of a malpractice action? |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal or state entity for any disciplinary reasons or while under investigation for disciplinary reasons? |

SECTION IV – REQUIREMENTS FOR REINSTATEMENT

- ☐ a. Dental continuing education. I have attached proof of completion of 8 classroom hours of dental continuing education, 4 hours of which are on the subject of radiation safety, taken within the 1-year period preceding application for reinstatement and in addition, proof of completion of a 2-hour Board approved course on infection control.

Release and Certification:

Practice of dental radiation technology without a current certification issued by the Maryland State Board of Dental Examiners is a violation of the Maryland Dentistry Act. I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Failure to provide truthful answers may result in disciplinary action.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for dental radiation technologist certification in Maryland from any person or agency, including but not limited to postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my practice as a licensed dental radiation technologist in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Annotated Code of Maryland, Health Occupations §4-315.

Applicant Signature

Date

NOTARY SECTION

State of _____, County of _____, Then personally appeared the above named _____, and signed and sworn to the truth of the foregoing statements in my presence.

Notary Public: _____ My Commission Expires: _____

SEAL

Revised 03/03/11

**MARYLAND STATE BOARD OF DENTAL EXAMINERS
GUIDELINES FOR REINSTATEMENT OF EXPIRED 2011
DENTAL RADIATION TECHNOLOGIST CERTIFICATE**

The Board may not process a licensure application until each provision or requirement is met and each document is received. Please ensure that your application is complete before it is submitted.

Reinstatement of Expired 2011 Dental Radiation Technologist Certification

An individual holding an expired certificate to practice dental radiation technology may apply for reinstatement if the applicant:

- (1) Completes a dental radiation technology reinstatement application; and
- (2) Provides proof of completion of 8 hours of dental continuing education from Board-approved courses, 4 hours of which shall be in radiology and in addition a 2-hour Board-approved course on infection control and;
- (3) Provides a notarized statement from their supervising dentist(s) indicating whether they have practiced dental radiation technology, which is the placement or exposure of dental radiographs, on or after April 2, 2011, and if yes, the dates; and
- (4) Pays to the Board a certification reinstatement fee of \$118.00.

To apply for reinstatement of licensure, you must submit the Application for Reinstatement of Expired 2011 Dental Radiation Technologist Certificate and enclose the following with your application:

- *A \$118 non-refundable fee.*
- *Proof of completion of 8 hours of continuing education, including at least 4 hours in radiology and a 2-hour Board-approved course on infection control. The course(s) must have been completed within one year preceding the date of your application for reinstatement.*
- *A notarized statement from your supervising dentist(s) whether you have practiced dental radiation technology, which is the placement or exposure of dental radiographs, on or after April 2, 2011, and if yes, the dates.*

Before submitting your application...

1. Is your application completed front and back?
2. Did you sign and have the application notarized?
3. Did you enclose a check or money order in the amount of \$118.00 made payable to the Maryland State Board of Dental Examiners?
4. Did you enclose proof of continuing education?
5. If you have changed your name, did you enclose proof of legal name change such as a marriage certificate, divorce decree, or other court document?
6. Did you enclose a notarized statement from your supervising dentist(s) indicating the most recent date(s) that you practiced dental radiation technology, which is the placement or exposure of dental radiographs, on or after April 2, 2011? If yes, please provide the dates.

MAIL APPLICATION AND SUPPORTING DOCUMENTS TO:

Maryland State Board of Dental Examiners
The Benjamin Rush Building
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, MD 21228
ATTN: Licensing Unit

Revised 03/03/11